

Section 4 - Organization and Administration of the Demonstration

ORGANIZATIONAL STRUCTURE

There are two primary state agencies responsible for health care in the State of Minnesota: the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS). The following is a brief overview of each agency's responsibilities as well as a brief description of key personnel. MDH and DHS will work closely in the development and implementation of special health initiatives established under this demonstration project.

Minnesota Department of Human Services (DHS). DHS is the State Medicaid agency responsible for providing and purchasing all health care services through fee-for-service and managed care models for Medical Assistance, General Assistance Medical Care, and MinnesotaCare enrollees. DHS supervises the counties in conducting eligibility determinations for MA and GAMC, and administers the MinnesotaCare Program directly at the state level. Statewide standards, investigations, enforcement, quality improvement and claims processing are conducted by DHS at the state level for all three programs. The Health Care Administration, within DHS, is responsible for all policy aspects and many operational aspects of these three programs.

Key personnel:

Michael O’Keefe is the Commissioner of Human Services.

Tom Moss is the Deputy Commissioner of Human Services.

Mary Kennedy, Assistant Commissioner of Health Care Administration, is responsible for the publicly-funded health care programs. She also serves as State Medicaid Director.

Ann Berg is the manager of the Federal Relations Unit, which is responsible for various activities related to ensuring that Minnesota draws federal funding in compliance with Title XIX requirements.

James Chase is the Director of Purchasing and Service Delivery, which includes policy development, rates, and purchasing for the Prepaid MA Program (PMAP), Prepaid GAMC (PGAMC), and Prepaid MinnesotaCare.

Vicki Kunerth is the Director of Performance Measurement & Quality Improvement, which includes quality assurance for managed care, performance management, and surveillance and integrity review.

Kathleen Henry is the Director of Health Care for Families with Children. This division is responsible for policy development and implementation related to eligibility for all MA, GAMC, and MinnesotaCare populations. The division supervises county

administration of MA, MinnesotaCare and GAMC eligibility, and administers MinnesotaCare eligibility.

Kathleen Vanderwall is responsible for Tribal relations, ongoing management of Minnesota's section 1115 demonstration projects, and development of new waiver initiatives.

Erin Sullivan Sutton is the Acting Assistant Commissioner of Family and Children's Services. She has responsibility for the Children's Mental Health Division.

George Hoffman is the Director of Reports and Forecasts in the Finance and Management Administration. He is responsible for forecasting expenditures for DHS programs.

Minnesota Department of Health (MDH). In the State of Minnesota, MDH is responsible for activities related to public health. It is also responsible for Medicare certification and licensing of nursing facilities, licensing of hospitals, health maintenance organizations, and community integrated service networks, among other health care providers. It develops public health care policy for the State, including disease prevention and control, health promotion, and control of environmental hazards.

Key personnel:

Jan Malcolm is the Commissioner of Health.

Julie Brunner is the Deputy Commissioner of Health.

Gayle Hallin is the Assistant Commissioner of the Family and Community Health Bureau. She directs two divisions: the Division of Community Health Services which includes the Offices of Rural Health and Primary Care, Community Development and Public Health Nursing; and the Division of Family Health, which includes the program for Minnesota Children with Special Health Needs, Maternal and Child Health, and Supplemental Nutrition Programs.

Aggie Leitheiser is the Assistant Commissioner of the Health Protection Bureau. Her duties include directing the Division of Environmental Health.

Scott Leitz supervises the Health Economics Program, which conducts research and applied policy analysis to monitor changes in the health care marketplace; to understand factors influencing health care cost, quality and access; and to provide technical assistance in the development of state health care policy. The information is used to inform policy makers, consumers, and other stake holders in Minnesota.

ADMINISTRATION OF THE DEMONSTRATION

DHS Health Care Administration supervises county administration of eligibility in Minnesota health care programs. DHS Health Care Administration also administers eligibility in MinnesotaCare.

DHS Family and Children's Services, Children's Mental Health Division, administers the programs that provide grants to counties for mental health services for children and adolescents, outreach and screening.

MDH has responsibility for environmental health, which includes responsibility for primary and secondary lead poisoning prevention activities, lowering of blood lead levels, and prevention of further exposure of those affected. MDH would be the administering agency of a special health initiative for blood lead hazard reduction.

WORK PLAN AND TIME LINE

The design of the waiver request is based on the ongoing participation of the Health Care Financing Administration (HCFA), the Minnesota Department of Human Services, the Minnesota Department of Health, the Minnesota Health Policy Commissioners, and major stakeholder groups. Minnesota considers the inclusion of major stakeholders essential in the development of special health initiatives. The work plan, like the waiver itself, is divided into two phases. The components to be immediately implemented are displayed as Phase One and those in Phase Two are identified as components requiring further development and input prior to implementation. The proposed effective date for the demonstration waiver is October 1, 1998.

Phase One. In phase one of the waiver, DHS will implement those projects that do not require legislative enactment. Upon HCFA approval of the waiver, DHS will be permitted to claim S-CHIP matching funds for costs related to increased enrollment over the September 1998 baseline. DHS will seek claims for increased MinnesotaCare enrollment in FFYs 99, 00 and 01 without changes to the MinnesotaCare premium structure. DHS will also seek the enhanced S-CHIP match for parents and caretakers enrolled in MinnesotaCare who have income above 100% and at or below 275% of the federal poverty levels.

Also in this phase, DHS will convert four special health initiatives currently in place to S-CHIP special health initiatives. These are the three mental health projects for children and adolescents: mental health screening in the juvenile court system; health care outreach and services for homeless children and adolescents; and mental health services for children without coverage. They would be converted to S-CHIP special health initiatives effective October 1, 1998. The fourth existing project involving infrastructure grants to improve access to dental services would also be converted to an S-CHIP special health initiative effective October 1, 1999.

Phase Two. This phase of the waiver demonstration requires legislative approval during the 2001 session for implementation of presumptive eligibility for Medicaid children, and adjustments to the MinnesotaCare premium schedule to conform to Title XXI requirements. . The earliest start date for both of these projects will be October 1, 2001, or later depending upon

the time needed for systems work.

The second major part of phase two is the development of other special health initiatives that meet the Public Health Improvement Goals. Federal revenue generated by phase one projects will create a fund from which to expand existing initiatives and implement new ones. DHS establish a steering committee that will establish new projects, authorize expenditures, and accept input from state and local agencies, advocates, providers, consumers, the public.

Administration of new special health initiatives is expected to be conducted as a grant process, utilizing request for proposals and a committee selection process.

Time Line

<u>Date</u>	<u>Task</u>
9/99	Baseline enrollment for claiming increased enrollment in MinnesotaCare, starting with FFY 2000.
10/1/99	Start date for claims under S-CHIP of existing DHS grant projects: <ul style="list-style-type: none">· DHS mental health screening for children in juvenile court;· outreach services for homeless adolescents· mental health services for children and adolescents· for dental infrastructure grants
7/00	DHS begins preparations for 2001 legislative session to propose adoption of presumptive eligibility, and adjustments to MinnesotaCare premium schedule. Includes drafting legislation and preparing budgets.
4/00 to 7/00 <u>12/00</u>	Negotiate terms and conditions of waiver
7/00 to 11/00 <u>1/00 to 5/00</u>	Implement accounting and systems changes necessary to claim and report enhanced S-CHIP match on increased enrollment in MinnesotaCare; and on existing DHS grant projects.
7/00 <u>1/01</u>	Begin process for public participation in developing other special health initiatives: establish steering committee to develop and authorize special health initiatives.
1/01	Submit legislative proposals to Minnesota Legislature, including adjustments to premium schedule, presumptive eligibility, and special health initiatives.
	<u>Begin claims for MinnesotaCare parents and caretakers with income</u>

above 100% and at or below 275% of poverty.

~~10/01~~ 01/02

Implement MinnesotaCare premium adjustment.
Implement presumptive eligibility in MA and MinnesotaCare

~~10/01~~ 01/02

Implement new special health initiatives